CONSUMER PHYSICAL EXAMINATION REPORT

Consumer Name:		Date of Exam:	
Birth Date:	Sex:	Height:	Weight:
Temp:	Pulse:	Resp:	BP:

MEDICATION: (Dosage & Time of Administration)	HISTORY OF SEIZURES:
GENERAL APPEARANCE:	NUTRITIONAL STATUS & HYGIENE:
SPEECH/HEARING/VISION:	ALLERGIES:

PAST HISTORY: Medical:

Surgical:

PHYSICIAN'S INSTRUCTIONS: (Make statement of each subject. Attach additional sheets if necessary)

SKIN

LYMPHATIC:

HEAD AND NECK:

E.E.N.T. (Include observations of Oral hygiene & condition of teeth):

CHEST & LUNGS:

ABDOMEN:

HEART:

HERNIA:

GENITALIA: Rectal-prostrate exam (Males)	Pelvic Exam: (Females) Pap Results
EXTREMITIES & BACK	
NERVOUS SYSTEM:	MENTAL STATUS:
REFLEXES:	
Pupils:	Gait:
Triceps:	Balance:
Patellar:	Coordination:
Abdominal:	Tremor:
Patellar:	
BREAST (Females only):	

TB TINE TEST: Date	Results:
Chest X-Ray required if Positive TB Test	
Date of X-Ray	Results:
Lab Tests Attach copies of Results	
Urinalysis:	CBC:
IMPRESSIONS:	
RECOMMENDATIONS:	
Client is free from communicable diseases and can physically participate in home/day program activities with the following restrictions:	

PHYSICIAN'S NAME:(Print)	ADDRESS:
PHONE:	
PHYSICIAN'S SIGNATURE:	DATE: